



Universal health coverage

Universal health coverage (UHC) has long been pursued as a public health and development objective. It embodies shared global values and is rooted in the principle of equity: all people, including the poorest and most marginalised, should be able to access the quality health services they need without suffering financial hardship.

Given the resource constraints of different countries, UHC does not imply the provision of all possible services, nor that all health interventions should be free. Instead, UHC should include the full spectrum of essential services, from health promotion to prevention and treatment, and is driven and influenced by contextual and political factors.

Embedded within the Sustainable Development Goals (SDGs), UHC is a priority for every United Nations member state that has committed to trying to attain it by 2030. Achieving UHC will not only enable countries to reach other SDG 3 targets (e.g. reducing the global maternal mortality ratio), but will also help them meet additional global goals (e.g. SDG 10 on reducing inequalities).

In September 2019, world leaders will make a Political Declaration on UHC, negotiated by member states and endorsed by heads of state. This moment will reinforce governments' commitments to meet national targets to achieve good health for all citizens, and Malaria Consortium will continue to support them to achieve this aim.

Malaria Consortium is one of the world's leading non-profit organisations specialising in the prevention, control and treatment of malaria and other communicable diseases among vulnerable populations.

Our mission is to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health.

Our approach and scope

Malaria Consortium considers UHC, as defined by the World Health Organization (WHO), fundamental to the design and implementation of all our programmes. Our tailored interventions seek to improve equity by providing quality health services to marginalised populations (particularly women and girls and those living in hard-to-reach areas) that are affordable for users. To ensure barriers to achieving UHC are addressed and to encourage sustainability, we work closely with governments to integrate our programmes within existing health systems and structures in the countries in which we work.

Malaria Consortium believes that [community-based primary healthcare](#) – whereby trained community health workers (CHWs) provide basic and essential health services to under-served communities in remote areas – is the key to unlocking health for all. This cost-effective approach has the potential to engage communities, strengthen health workforces and serve as an entry point for building comprehensive primary healthcare systems.

As part of our contribution to supporting countries to achieve UHC, we have developed and implemented projects that have provided:

- preventive treatment for infectious diseases, including malaria and a range of neglected tropical diseases (NTDs)
- vector control activities to limit the ability of mosquitoes or other insects to spread disease
- case management (diagnosis and treatment) of malaria, pneumonia, diarrhoea, dengue, NTDs and malnutrition
- access to and delivery of a range of maternal and child health services at the community and primary healthcare level
- increased health systems effectiveness and efficiency by ensuring projects are integrated with existing structures and health workers are trained and supported to address the health needs of communities.

In developing these evidence-based interventions, we consider public and private health providers, affordability, equity, the quality of care provided and sustainability.

Our expertise

Malaria Consortium's projects and approaches are rooted in the following four core dimensions of UHC.

1. Equity

Mainstreaming gender and equity into the fight against malaria

In Uganda, malaria transmission rates remain persistently high in most areas of the country, and gender and age are important social determinants of the disease. As we are seeking to prevent and control malaria in the country via the USAID-funded Malaria Action Program for Districts project, we conducted gender and equity analyses to understand the dynamics behind women's, men's, girls' and boys' differential exposure to the disease and practice of related preventive behaviours.

The findings shaped the project's design, including: gender and age-specific community dialogues on the prevention, treatment and control of malaria; gender and youth-related malaria talking points for District Health Management Teams, community health leaders and local leaders; a gender and youth integration checklist for project staff; and a gender and youth-responsive community dialogue guide.

Further reading: <http://bit.ly/2Yxg8fe>

Using participatory community engagement to reduce inequities for improved health outcomes

Developed by Malaria Consortium, the Community Dialogue Approach has been used across a range of countries and health issues to improve awareness and increase the use of available health services. It offers a bottom-up approach that encourages engagement with all sections of the community, thereby strengthening community ownership of health issues and supporting equitable access to care.

The approach has been found to be feasible and well-accepted by communities. In Mozambique, a community dialogue intervention increased knowledge among communities of schistosomiasis prevention and control and adoption of protective practices. Meanwhile, in Bangladesh, preliminary findings from a community dialogue intervention to address the misuse of antibiotics included decisions by communities not to buy antibiotics without a prescription and to visit the community clinic if unwell, as well as encouraged handwashing among community members.

Further reading: <http://bit.ly/2VGyOvV>

2. Quality

Expanding access to quality health services

Rural communities in western Myanmar are often poorly served by the country's public health system and have limited access to vital services due to their remoteness. Since 2016, we have been increasing the provision and quality of health services for these communities by piloting and then scaling up the delivery of integrated community case management of malaria and childhood illnesses through the country's existing network of malaria volunteers.

This involved establishing regular training and effective supervision processes for the volunteers delivered by basic health staff – themselves part of the formal health system – to ensure and strengthen the quality of their services. This includes their ability to accurately test, treat and refer cases of malaria, diarrhoea, pneumonia and malnutrition in children under five using WHO-endorsed diagnosis tools and treatment protocols).

Before this project began, malaria volunteers were only trained to provide malaria case management. Between March 2018 and January 2019, they diagnosed over 1,800 cases of pneumonia in children under five years by assessing respiratory rates; diagnosed and treated more than 1,700 cases of diarrhoea by taking case histories and providing oral rehydration salts; screened over 8,800 under-fives for malnutrition using mid-upper arm circumference measurements; and tested more than 4,000 cases of fever for malaria using rapid diagnostic tests (mRDTs).

Further reading: <http://bit.ly/2LbBGHz>

Strengthening the provision and quality of primary healthcare

Malaria still poses a significant barrier to social and economic development in Ethiopia, despite recent reductions in malaria-related morbidity and mortality. The country aims to eliminate malaria by 2030 and is implementing essential malaria control and elimination interventions to achieve this goal.

Through the USAID-funded Transform: Primary Health Care project (2017–2021), we are supporting the Government of Ethiopia in these efforts, seeking to strengthen the quality of services provided across the primary health continuum of care in Amhara, Tigray, Oromia and the Southern Nations, Nationalities and Peoples' Region. We are building the capacity of antenatal care providers to deliver improved malaria case management; capturing accurate data on malaria in pregnancy (a prerequisite for data-informed decision-making that should improve treatment and ultimately contribute to building a stronger health system); and providing technical assistance for undertaking quality assessments for rapid diagnostic testing of malaria and other activities.

Within one year of the project starting, the percentage of severe malaria cases that were treated correctly increased by 32 percent (from 72 percent in 2017 to 95 percent in 2018).

Further reading: <http://bit.ly/2HqE91T>

3. Affordability

Stimulating markets to provide affordable and quality-assured malaria commodities

Diagnosis is one of many crucial components in the fight against malaria and in low-income settings mRDTs are the best tools available. However, affordability for consumers remains a key challenge.

Under the Unitaid-funded DeFEAT project (2013-2016), we supported the creation of private sector markets for quality-assured mRDTs in Nigeria and Uganda. We collaborated with manufacturers and provided incentives (subsidies) along the supply chain to stimulate the market to provide mRDTs at more affordable prices. As a result, mRDTs became cheaper than artemisinin-based combination therapies and, consequently, consumer demand for testing before undergoing treatment increased.

The project was successful in catalysing markets in both countries. In Uganda, 657,950 mRDTs were sold to 1,502 private providers over 20 months, while in Nigeria 1,200,000 mRDTs were sold to 868 private providers in 19 months.

Project data were also used by WHO to engage the public and private sectors in strengthening policies and creating regulatory frameworks for malaria case management in Nigeria and Ethiopia.

Further reading: <http://bit.ly/2HuG2t6>

Delivering cost-effective seasonal malaria chemoprevention

Across the Sahel, most childhood malarial infections and deaths occur during the rainy season. Seasonal malaria chemoprevention (SMC) prevents malarial illness throughout this period of greatest malarial risk. This WHO-endorsed intervention is needed by approximately 25 million children in the region. However, limited information on the key cost drivers of SMC and competing funding priorities led to significant barriers for scaling up the intervention: in 2013, only four percent of eligible children received SMC.

In response, we led a consortium of partners to deliver SMC in seven countries under the Unitaid-funded Achieving Catalytic Expansion of SMC in the Sahel (ACCESS-SMC) project. By improving demand forecasting and ensuring centralised procurement of affordable, quality-assured SMC, the project helped catalyse the supply market for this cost-effective malaria intervention. This was complemented by a range of tailored social behaviour change activities and the use of multiple distribution methods including door-to-door visits by CHWs. Over three years of implementation (2015–2017), data estimate that the project may have averted over 60,000 deaths and prevented over 10 million cases of malaria.

Furthermore, surveys we conducted in 2015–2016 across the seven countries revealed that, on average, SMC cost less than US\$5 (£4) per child treated each year. Preliminary analysis of potential health systems savings and cost-effectiveness also shows that SMC may have saved health systems over \$120 million (£94 million) in terms of diagnosis and treatment costs and that SMC is comparable to other malaria interventions in terms of cost-effectiveness.

Further reading: <http://bit.ly/2RtNc3x>

4. Sustainability

Supporting governments to reduce malaria morbidity and associated mortality

In 2017, Nigeria accounted for 25 percent of malaria cases globally, making it one of the highest burden countries in the world. We are assisting the Government of Nigeria to reduce the country's malaria burden through the UK aid-funded Support to the National Malaria Programme 2 (SuNMaP 2) project. Between 2018 and 2024, we will build on the success of the earlier SuNMaP project (2008–2016) and integrate malaria prevention, treatment, and other interventions at the community and service delivery levels, through public and private sector partnerships.

Government involvement and stewardship of SuNMaP 2, including via the allocation and release of funds, is essential to ensuring that the interventions are sustainable. Therefore, we and our partners are working in collaboration with government structures at the national and sub-national levels to coordinate and harmonise the planning, implementation and evaluation of the project's interventions.

Further reading: <http://bit.ly/2HnUIRh>

Working with governments to use digital health

We are supporting the Mozambican government to secure by 2022 nationwide coverage of upSCALE, a digital health platform that aims to improve the quality, coverage and management of community-based primary healthcare. The platform consists of a multimedia mobile phone app that supports CHWs' decision-making and enables automated reporting of key indicators; a tablet-based app for supervisors that facilitates monitoring and assessment of CHWs' performance; and a community health information management system for synthesis and visualisation of data at district, provincial and national levels.

To promote its sustainability from the outset, we aligned the upSCALE platform with national guidelines for community-based care and developed the system in conjunction with CHWs and other programme staff. Key to upSCALE's sustainability has been Ministry of Health ownership and drive to scale up the platform nationally. We have collaborated with Unicef to strengthen local capacity at all levels, with the assumption that the Mozambican government will take over platform rollout and management. This has included: setting up contracts with provincial phone repair companies, working closely with district and provincial staff to incorporate upSCALE costs within budget requests, transitioning to local hosting, and integrating upSCALE with wider government systems.

Further reading: <http://bit.ly/2lbV36C>



Community health worker checks the malnutrition status of a child, Myanmar


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Cover image: Child recipient of SMC medication, Burkina Faso

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